		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045138

Facility Name: COTILLION RIDGE NURSING CENTER

Address: 600 EAST ROBINWOOD DRIVE (Number) ROBINSON (City) 62454 (Zip Code)

County: Crawford

Telephone Number: (618) 544-3192 **Fax #** ( )

HFS ID Number: 371402726

Date of Initial License for Current Owners: 2000

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Craig L. Ater
(Title) Senior V.P. & CFO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	73	Skilled (SNF)	73	26,645	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,139	9,220	3,158	25,517	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	13,139	9,220	3,158	25,517	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.77%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 2000

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 3,158

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	115,881	9,844		125,725		125,725	3,222	128,947			1
2	Food Purchase		113,473		113,473		113,473		113,473			2
3	Housekeeping	65,554	15,135		80,689		80,689	3	80,692			3
4	Laundry	31,512	9,160		40,672		40,672		40,672			4
5	Heat and Other Utilities			51,073	51,073		51,073	1,017	52,090			5
6	Maintenance	63,314	19,097	25,490	107,901		107,901	8,522	116,423			6
7	Other (specify):*											7
8	**TOTAL General Services**	276,261	166,709	76,563	519,533		519,533	12,764	532,297			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	1,066,744	75,796	3,957	1,146,497		1,146,497		1,146,497			10
10a	Therapy		201,257	377,959	579,216	(319,703)	259,513	104,754	364,267			10a
11	Activities	36,968	2,012		38,980		38,980		38,980			11
12	Social Services	28,870	990	5,255	35,115		35,115		35,115			12
13	CNA Training							1,145	1,145			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,132,582	280,055	403,671	1,816,308	(319,703)	1,496,605	105,899	1,602,504			16
	C. General Administration											
17	Administrative	69,193			69,193		69,193	47,275	116,468			17
18	Directors Fees							3,667	3,667			18
19	Professional Services			240,687	240,687		240,687	(230,497)	10,190			19
20	Dues, Fees, Subscriptions & Promotions			61,747	61,747	(39,968)	21,779	(11,592)	10,187			20
21	Clerical & General Office Expenses	101,703	10,784	8,416	120,903		120,903	104,094	224,997			21
22	Employee Benefits & Payroll Taxes			305,846	305,846		305,846	26,540	332,386			22
23	Inservice Training & Education			529	529		529	859	1,388			23
24	Travel and Seminar			14,519	14,519		14,519	(12,520)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,316	50,316		50,316	1,301	51,617			26
27	Other (specify):*			10,500	10,500		10,500	(10,500)				27
28	**TOTAL General Administration**	170,896	10,784	692,560	874,240	(39,968)	834,272	(81,373)	752,899			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,579,739	457,548	1,172,794	3,210,081	(359,671)	2,850,410	37,290	2,887,700			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER #0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			99,796	99,796		99,796	8,648	108,444			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,226	29,226		29,226	10,621	39,847			32
33	Real Estate Taxes			20,243	20,243		20,243		20,243			33
34	Rent-Facility & Grounds			282,502	282,502		282,502	4,466	286,968			34
35	Rent-Equipment & Vehicles			3,798	3,798		3,798	3,124	6,922			35
36	Other (specify):*											36
37	**TOTAL Ownership**			435,565	435,565		435,565	26,859	462,424			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					319,703	319,703		319,703			39
40	Barber and Beauty Shops			16,985	16,985		16,985		16,985			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					39,968	39,968		39,968			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			16,985	16,985	359,671	376,656		376,656			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,579,739	457,548	1,625,344	3,662,631		3,662,631	64,149	3,726,780			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	2,003	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(4,434)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(900)	20		17
18	Fines and Penalties				18
19	Entertainment	(19,317)	24		19
20	Contributions	(300)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,454)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,200)	27		24
25	Fund Raising, Advertising and Promotional	(13,793)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (57,395)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	121,544		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 121,544		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 64,149		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

COTILLION RIDGE NURSING CENTER

ID# 0045138

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		$			1
2					2
3					3
4					4
5			2,003	35	5
6			0	34	6
7					7
8					8
9			0	30	9
10				32	10
11					11
12					12
13			0	2	13
14				32	14
15			0	33	15
16				24	16
17			(900)	20	17
18					18
19				24	19
20			(300)	27	20
21					21
22			(10,454)	19	22
23					23
24			(10,200)	27	24
25			(13,793)	20	25
26					26
27					27
28					28
29			0	23	29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49	**Total**		(33,644)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number COTILLION RIDGE NURSING CENTER **#** 0045138 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,222	0	0	0	0	0	0	0	0	3,222	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	3	0	0	0	0	0	0	0	0	3	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,017	0	0	0	0	0	0	0	0	1,017	5
6	Maintenance	0	0	8,522	0	0	0	0	0	0	0	0	8,522	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	12,764	0	0	0	0	0	0	0	0	12,764	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	104,754	0	0	0	0	0	0	0	0	0	104,754	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,145	0	0	0	0	0	0	0	0	1,145	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	104,754	1,145	0	0	0	0	0	0	0	0	105,899	16
	C. General Administration													
17	Administrative	0	0	47,275	0	0	0	0	0	0	0	0	47,275	17
18	Directors Fees	0	0	3,667	0	0	0	0	0	0	0	0	3,667	18
19	Professional Services	(10,454)	(230,233)	10,190	0	0	0	0	0	0	0	0	(230,497)	19
20	Fees, Subscriptions & Promotions	(14,693)	0	3,101	0	0	0	0	0	0	0	0	(11,592)	20
21	Clerical & General Office Expenses	0	0	104,094	0	0	0	0	0	0	0	0	104,094	21
22	Employee Benefits & Payroll Taxes	0	0	26,540	0	0	0	0	0	0	0	0	26,540	22
23	Inservice Training & Education	0	0	859	0	0	0	0	0	0	0	0	859	23
24	Travel and Seminar	(19,317)	0	6,797	0	0	0	0	0	0	0	0	(12,520)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,301	0	0	0	0	0	0	0	0	1,301	26
27	Other (specify):*	(10,500)	0	0	0	0	0	0	0	0	0	0	(10,500)	27
28	**TOTAL General Administration**	(54,964)	(230,233)	203,824	0	0	0	0	0	0	0	0	(81,373)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(54,964)	(125,479)	217,733	0	0	0	0	0	0	0	0	37,290	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER **#** 0045138 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	8,648	0	0	0	0	0	0	0	8,648	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,434)	0	0	15,055	0	0	0	0	0	0	0	10,621	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	4,466	0	0	0	0	0	0	0	4,466	34
35	Rent-Equipment & Vehicles	2,003	0	0	1,121	0	0	0	0	0	0	0	3,124	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,431)	0	0	29,290	0	0	0	0	0	0	0	26,859	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(57,395)	(125,479)	217,733	29,290	0	0	0	0	0	0	0	64,149	45

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	230,233	Heritage Enterprises, Inc.	100.00%		(230,233)	4
5	V								5
6	V	10a	Adjustment for Related Organization	198,688	GreenTree Pharmacy	100.00%	303,442	104,754	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 428,921			$ 303,442	$ * (125,479)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 3,222	$ 3,222	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				3	3	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,017	1,017	19
20	V	6	Maintenance				8,522	8,522	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,145	1,145	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				47,275	47,275	29
30	V	18	Directors Fees				3,667	3,667	30
31	V	19	Professional Services				10,190	10,190	31
32	V	20	Fees, Subscription, Promotions				3,101	3,101	32
33	V	21	Clerical & General Office Expenses				104,094	104,094	33
34	V	22	Employee Benefits & Payroll Taxes				26,540	26,540	34
35	V	23	Inservice Training & Education				859	859	35
36	V	24	Travel and Seminar				6,797	6,797	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,301	1,301	38
39	Total			$			$ 217,733	$ * 217,733	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$	$ 0	15
16	V	30	Depreciation					8,648	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					15,055	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,466	20
21	V	35	Rent-Equipment & Vehicles					1,121	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 29,290	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Cheryl Lowney	Executive Vice Presi	Management	20.00		40	100.00	Salary/BOD	$ 10,188	Ln 17/18	1
2	Steve Wannemacher	President	Management	20.00		40	100.00	Salary/BOD	10,188	Ln 17/18	2
3	Connie Hoselton	Sr Vice President	Management	20.00		40	100.00	Salary/BOD	10,188	Ln 17/18	3
4	Craig Ater	Sr Vice President	Management	20.00		40	100.00	Salary/BOD	10,188	Ln 17/18	4
5	Joseph Warner Marital Trust			20.00					10,188	Ln 17/18	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 50,942		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES xx NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington,Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	$ 115,289	$ 115,276	73	$ 3,222	1
2	2	Food Purchase	Beds	2,612	25	7	0	73	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	73	3	3
4	4	Laundry	Beds	2,612	25	0	0	73	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	73	1,017	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	73	8,522	6
7	7	Other	Beds	2,612	25	0	0	73	0	7
8	9	Medical Director	Beds	2,612	25	0	0	73	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	73	0	9
10	11	Activities	Beds	2,612	25	0	0	73	0	10
11	12	Social Service	Beds	2,612	25	0	0	73	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	73	1,145	12
13	14	Program Transportation	Beds	2,612	25	0	0	73	0	13
14	15	Other	Beds	2,612	25	0	0	73	0	14
15	17	Administrative	Beds	2,612	25	1,691,552	1,691,552	73	47,275	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	73	3,667	16
17	19	Professional Services	Beds	2,612	25	364,592	0	73	10,190	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	73	3,101	18
19	21	Clerical & General Office Expens	Beds	2,612	25	3,724,581	3,385,972	73	104,094	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,612	25	949,625	0	73	26,540	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	73	859	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	73	6,797	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	73	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	73	1,301	24
25	TOTALS					$ 7,790,758	$ 5,312,886		$ 217,733	25

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	$	$	73	$	1
2	30	Depreciation	Beds	2,612	25	309,426		73	8,648	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			73		3
4	32	Interest	Beds	2,612	25	538,695		73	15,055	4
5	33	Real Estate Taxes	Beds	2,612	25			73		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		73	4,466	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		73	1,121	7
8	36	Other	Beds	2,612	25			73		8
9	38	Medically Nec Transportation	Beds	2,612	25			73		9
10	39	Ancillary Service Centers	Beds	2,612	25			73		10
11	40	Barber and Beauty Shops	Beds	2,612	25			73		11
12	41	Coffee and Gift Shops	Beds	2,612	25			73		12
13	42	Other	Beds	2,612	25			73		13
14								73		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,048,023	$		$ 29,290	25

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Alpha Community Bank		xx	Mortgage	$12,808.00	11/1/00	$	$ 414,590	05/1/07	variable	$ 28,409	1
2	Loan Fee Amort		xx	Mortgage							817	2
3												3
4												4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital							15,055	6
7	Central Office Allocation		xx	Working Capital								7
8												8
9	TOTAL Facility Related				$12,808.00		$	$ 414,590			$ 44,281	9
	B. Non-Facility Related*											
10	Interest Income										(4,434)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,434)	14
15	TOTALS (line 9+line14)						$	$ 414,590			$ 39,847	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER **#** 0045138 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	18,244	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	18,774	2
3. Under or (over) accrual (line 2 minus line 1).	$	530	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	19,713	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	20,243	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001	16,294	9
2002	17,273	10
2003	17,140	11
2004	17,374	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COTILLION RIDGE NURSING CENTER COUNTY Crawford

FACILITY IDPH LICENSE NUMBER 0045138

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-4-27-033-041-000	COTILLION RIDGE NURSING CEN	$ 243.00	$ 243.00
2.	05-4-27-033-042-000		$ 18,531.00	$ 18,531.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 18,774.00	$ 18,774.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,195 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [xx] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	73				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Acquisition of Building Improvements from prior Operator			2001	154,177						9
10											10
11	Dinning Room/Day Room Addition---Outside Contractor			2001	164,291						11
12	Dinning Room/Day Room Addition---Design			2001	50,288						12
13	Dinning Room/Day Room Addition---Wallcoverings			2001	9,670						13
14											14
15	Dinning Room/Day Room Addition---Outside Contractor			2002	66,633						15
16	Dinning Room/Day Room Addition---Design			2002	4,665						16
17	Heating Duct Replacement			2002	12,146						17
18											18
19	Dinning Room/Day Room Addition---Paid by ProCare			2002	200,750						19
20	directly to General Contractor										20
21											21
22	Heat Pump			2003	12,720						22
23	Compressor			2003	1,333						23
24	A/C Unit			2003	2,569						24
25	Water Heater			2003	7,262						25
26	Sprinkler Head Replacements			2003	3,993						26
27	Asphalt Sealing			2003	1,260						27
28	idph			2003	8,618						28
29											29
30	Rewire Resident Rooms			2004	3,250						30
31											31
32											32
33											33
34	C/O Allocation							8,648	8,648		34
35	Book Depreciation					33,844		33,844		135,043	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Parking Lot Sealer	2005	1,260						38
39	Doors	2005	660						39
40	A/C compressor	2005	983						40
41	Sidewalk	2005	7,898						41
42	Ansul System	2005	1,990						42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 716,416	$ 33,844		$ 42,492	$ 8,648	$ 135,043	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 716,416	$ 33,844		$ 42,492	$ 8,648	$ 135,043	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 716,416	$ 33,844		$ 42,492	$ 8,648	$ 135,043	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 506,777	$ 65,952	$ 65,952	$		$ 326,969	71
72	Current Year Purchases	5,622						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 512,399	$ 65,952	$ 65,952	$		$ 326,969	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,228,815	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 99,796	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 108,444	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,648	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 462,012	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ProCare, Inc.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		73	11/1/00	$ 282,502	10	10	3
4	Additions							4
5								5
6								6
7	TOTAL		73		$ 282,502 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [xx] YES [ ] NO Terms: $1,550,000 purchase *

10. Effective dates of current rental agreement:
Beginning 11/1/00
Ending 11/1/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$ 282,502
13.	/2007	$ 282,502
14.	/2008	$ 282,502

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 6,922 Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - ☐ YES
   - ☐ NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 120,685	$		$ 120,685	1
2	Licensed Speech and Language Development Therapist		hrs			56,099			56,099	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			186,982	500		187,482	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				305,510		305,510	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					14,193			14,193	13
14	TOTAL			$		$ 377,959	$ 306,010		$ 683,969	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number COTILLION RIDGE NURSING CENTER **#** 0045138 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 133,643	$	1
2	Cash-Patient Deposits	1,646		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	400,479		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,178		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(43,304)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 508,642	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	515,686		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	463,149		16
17	Accumulated Depreciation (book methods)	(462,012)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	148,158		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 664,981	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,173,623	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 100,166	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,646		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,713		32
33	Accrued Interest Payable	2,391		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(4,972)		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 118,944	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	414,590		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 414,590	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 533,534	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 640,089	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,173,623	$	48

***(See instructions.)**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER **#** 0045138 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 813,837	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 813,837	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	156,252	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(330,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (173,748)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 640,089	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,537,581	1
2	Discounts and Allowances for all Levels	(1,061,340)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,476,241	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	975,373	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 975,373	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	18,591	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	344,244	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 362,835	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,434	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,434	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,818,883	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	519,533	31
32	Health Care	1,816,308	32
33	General Administration	874,240	33
	B. Capital Expense		
34	Ownership	435,565	34
	C. Ancillary Expense		
35	Special Cost Centers	16,985	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,662,631	40
41	**Income before Income Taxes (line 30 minus line 40)****	156,252	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 156,252	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,968	2,138	$ 42,570	$ 19.91	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	13,002	14,380	257,819	17.93	3
4	Licensed Practical Nurses	8,919	9,152	140,989	15.41	4
5	CNAs & Orderlies	53,582	56,319	517,104	9.18	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,842	9,470	108,262	11.43	8
9	Activity Director					9
10	Activity Assistants	3,825	4,380	36,968	8.44	10
11	Social Service Workers	1,957	2,160	28,870	13.37	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,017	15,135	115,881	7.66	15
16	Dishwashers					16
17	Maintenance Workers	6,163	6,659	63,314	9.51	17
18	Housekeepers	7,747	8,403	65,554	7.80	18
19	Laundry	3,288	3,567	31,512	8.83	19
20	Administrator	1,900	2,080	69,193	33.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,938	6,649	101,703	15.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,148	140,492	$ 1,579,739 *	$ 11.24	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		16,500		36
37	Medical Records Consultant		1,140		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,070		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		5,255		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,965		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Brush	admin		$ 69,193
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,193

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	admin	$ 230,233
		0
		0
		0
Legal--Adjusted to Zero		10,454
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 240,687

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,443
Unemployment Compensation Insurance	26,830
FICA Taxes	120,850
Employee Health Insurance	99,080
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	15,643
Employee Benefits - central office	26,540
TOTAL (agree to Schedule V, line 22, col.8)	$ 332,386

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	1,418
Health Care Worker Background Check	
(Indicate # of checks performed)	490
Central Office Allocation	3,101
Promotional Advertising	7,015
Public Relations	6,778
Dues and Subscriptions	6,078
License and Fees	0
Less: Public Relations Expense	(6,778)
Non-allowable advertising	(900)
Yellow page advertising	(7,015)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,187

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	7,403
	151
Seminar Expense	6,965
	(19,317)
	6,797
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number COTILLION RIDGE NURSING CENTER # 0045138 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **39,968**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **1,495**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

BASIC CHARGE-PRIVATE & VA	-3,364,511	
PRIVATE ASSESSMENT TAX INCOME		
BASIC CHARGE-IPA	0	
BASIC CHARGE-MEDICARE	0	
DAY CARE/HOME CARE		
LIGHT NURSING CARE	0	
MEDIUM NURSING CARE		
HEAVY NURSING CARE		
SPECIALTY NURSING CARE		
NURSING SUPPLIES-PRIVATE	-170,572	
NURSING SUPPLIES-IPA		
NURSING SUPPLIES MED PT A		
NURSING SUPPLIES MED PT B		
DRUGS	-344,244	
DRUGS-OTHER		
PT-PRIVATE	-975,373	
PT-IPA		
PT-MEDICARE PART A		
PT-MEDICARE PART B		
PT-MEDICARE ASSESSMENT INC		
LABORATORY INCOME		
SPEECH/OT-PRIVATE		
SPEECH/OT-IPA		
SPEECH/OT-MED PART A		
SPEECH/OT MED PART B		
IPA DISCOUNTS	1,861,340	
MEDICAID PART B DISCOUNT		
MEDICARE DISCOUNTS		
ASSESSMENT TAX EXPENSE		
RENT INCOME	0	
BEAUTY SHOP	-18,586	
ACTIVITY FUND INCOME	0	
ACTIVITY FUND EXPENSE	0	
MANAGEMENT FEES		
EQUIPMENT RENTAL	-498	
RESIDENT TRANSPORTATION	0	
MISC INCOME	0	
GENERAL & ADMINIST WAGES	94,560	101,703
ADMINISTRATOR WAGES	69,193	69,193
VACATION & SICK - G&A	7,143	
EMPLOYEE BENEFITS	115,523	305,846
EMPLOYEE HEPETITIS VACCINE	0	
EMPLOYEE SCHOLORSHIP WAC	0	
EMPLOYEE SCHOLORSHIP COST	320	
DIRECTORS FEES		
OFFICE EXPENSES	10,784	10,784
TELEPHONE	8,416	8,416
TRAINING & EMPLOYEE DEVL	529	529
GENERAL TRAVEL	7,403	14,519
MEAL EXPENSE FOR TRAVEL	151	
EDUCATION & SEMINAR	6,965	
HELP WANTED ADVERTISING	1,418	61,747
PROMOTIONAL ADVERTISING	7,015	
PUBLIC RELATIONS	4,778	
LICENSES & FEES	19,068	
DUES & SUBSCRIPTIONS	4,078	
CONTRIBUTIONS	880	
PROFESSIONAL FEES	10,454	240,687
AUDIT & LEGAL FEES	14,580	16,580
UTILIZATION REVIEW	0	
OTHER PHYSICIAN FEES	0	
MEDICAL RECORDS CONSULT	1,140	
PHARMACIST FEES	2,070	
SOC SERV/ACT CONSULT	5,255	5,255
TV RENTAL	-3,514	
INCOME TAXES		10,580
BACKGROUND CHECKS	490	
PAYROLL TAXES	141,979	
PAYROLL TAXES ADMINIST	5,701	
UNEMPLOYMENT	99,660	
LIABILITY INSURANCE	50,316	50,316
INSURANCE-OWNERS		
WORKMENS COMP INSURANCE	43,443	
CENTRAL OFFICE FEES	210,233	
BAD DEBTS	10,200	
LOST ITEMS-RESIDENTS	0	
MISCELLANEOUS	0	
REAL ESTATE TAXES	20,243	20,243
LEASED EQUIPMENT	7,312	3,708
MAINTENANCE SALARIES	58,799	63,314
MAINTENANCE SICK & VAC	3,515	
ELECTRIC	35,838	51,073
NATURAL GAS	6,577	
HEATING & DIESEL OIL		
WATER & SEWER	8,058	
TRASH COLLECTION	7,502	25,400
PROPERTY PLANT REPLACEMN	2,690	19,097
GENERAL REPAIR & MAINT	16,407	
MAINTENANCE CONTRACTS	17,988	
DIETARY WAGES	108,582	115,881
DIETARY SICK & VAC	7,579	
SALES TAX		
FOOD PURCHASES	114,968	113,473
SUPPLIES-DISHWASHING	2,586	9,864
DIETARY REPLACEMENT	701	
DIETARY SUPPLIES-PAPER	6,758	
MEAL CREDIT	-1,495	
LAUNDRY WAGES	29,621	31,512
LAUNDRY SICK & VAC	1,891	
LAUNDRY REPLACEMENT	3,746	9,160
LAUNDRY REIMBURSEMENT		
LAUNDRY SUPPLIES	5,414	
HOUSEKEEPING WAGES	61,050	65,554
HOUSEKEEPING SICK & VAC	4,504	
HOUSEKEEPING SUPPLIES	0	15,135
HOUSEKEEPING SUPPLIES-PPE	15,135	
RN WAGES-MEDICARE		1,066,744
RN WAGES-NON MEDICARE	258,878	
RN WAGES	412,567	
ADON	0	
RN SICK & VACATION	18,941	
LPN WAGES-MEDICARE	0	
LPN WAGES-NON MEDICARE	136,169	
LPN WAGES OTHER		
LPN SICK & VACATION	4,820	
AIDE WAGES-MEDICARE		
AIDE WAGES-NON MEDICARE	472,388	
WARD CLERKS		
AIDE VACATION & SICK	44,716	
CONTRACT NURSES-RN	0	
CONTRACT NURSES-LPN	0	
CONTRACT NURSES-AIDES	0	
NURSE AIDE TRAINING WAGES	0	0
NURSE AID TRAINING EXP	0	0
NURSE AIDE TRAINING REIMB	0	
REHAB WAGES	103,048	
REHAB SICK & VAC	5,214	
NURSING DEPT EDUCATION		
NURSING SUPPLIES	66,489	75,796
NURSING SUPPLIES	4,818	
REPLACEMENT-NURSING	2,489	
NURSING-OTHER	747	3,927
DRUG PURCHASES	83,256	201,257
DRUG PURCHASES-OTHER	117,201	
LABORATORY SERVICES	14,156	377,959
HOME HEALTH SALARY		
HOME HEALTH SICK & VAC		
HOME HEALTH EXPENSES		
ACTIVITES WAGES	34,693	36,968
ACTIVITIES SICK & VAC	2,275	
ACTIVITIES SUPPLIES	2,012	2,012
ACTIVITIES FEES	0	0
PT WAGES		
PT SICK & VACATION		
PT FEES	186,983	
PT SUPPLIES	500	
SOCIAL SERVICE WAGES	26,985	28,870
SOCIAL SERVICE SICK & VAC	1,885	
SOCIAL SERVICE EXPENSES	990	990
OT FEE	120,685	
SOCIAL THERAPIST FEE	0	0
SPEECH THERAPY FEE	56,099	
BEAUTICIAN WAGES		0
BEAUTICIAN SICK & VAC		
BEAUTICIAN FEES	14,985	16,985
BEAUTY SHOP SUPPLIES	0	0
VOLUNTEER COORDINATOR		
VOL COORD SICK & VAC		
VOL COORD SUPPLIES	0	
RENT	282,560	282,502
INTEREST EXPENSE	28,489	29,226
DEPRECIATION	99,796	99,796
LOAN FEE AMORTIZATION	817	
INTEREST INCOME	-4,434	
MISC NON-OPERATING INCOME	0	
INCOME TAXES	0	
	3,658,197	3,662,631
		4,434
	-156,252	
	(NET INCOME)	
	0	